

**General Assembly**

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Sixty-fifth session**Agenda item 10****Implementation of the Declaration of Commitment on
HIV/AIDS and the Political Declaration on HIV/AIDS****Uniting for universal access: towards zero new HIV
infections, zero discrimination and zero AIDS-related deaths****Report of the Secretary-General***Summary*

The year 2011 marks 30 years of AIDS. In that time, AIDS has claimed more than 25 million lives and more than 60 million people have become infected with HIV. Still, each day, more than 7,000 people are newly infected with the virus, including 1,000 children. No country has escaped the devastation of this truly global epidemic.

Nevertheless, HIV programmes are now bearing fruit, with global HIV incidence declining, treatment access expanding and an unparalleled global movement mobilized to demand respect for the dignity and human rights of everyone vulnerable to, and affected by, HIV. The epidemic and the response it has generated have changed our world, elevating global health inequity on the worldwide political agenda and placing people at the centre of health, development and human rights efforts.

These accomplishments, while promising, are insufficient and in jeopardy. Stigma, discrimination and gender inequality continue to undermine efforts to achieve universal access to HIV prevention, treatment, care and support. An unsustainable trajectory of costs and the effects of a global economic downturn combine to threaten progress.

For three decades, evidence of what works has been debated in the General Assembly, parliaments, communities, places of worship and scientific forums. The international community enters the fourth decade with a vast body of knowledge and an array of new tools to revolutionize prevention efforts and dramatically scale up access to treatment, care and support.



The HIV response faces a moment of truth: 2011 marks a unique opportunity to take stock of progress and to critically and honestly assess the barriers that keep us shackled to a reality in which the epidemic continues to outpace the response.

Bold decisions must be taken to dramatically reshape the AIDS response to reach zero new HIV infections, zero discrimination and zero AIDS-related deaths. This requires rejuvenated political commitment for more focused, efficient and sustainable responses. It requires recognition that non-discrimination, pragmatism and compassion will yield benefits not only for the HIV response but also across health, development and human rights priorities.

Bridging the gaps

- For every person starting treatment, two are newly infected. Ending new HIV infections will require harnessing innovation, putting people living with HIV at the centre of the response, protecting human rights and eliminating gender inequality.
- Global AIDS resources have flatlined. Shared responsibility is required to protect access for more than six million people receiving HIV treatment and to bring treatment to the millions who are still in need.
- The trajectory of costs is wholly unsustainable. Resources must be focused on evidence-informed actions that will generate efficiency and sustainable results while promoting country- and people-owned responses.
- HIV responses must take advantage of the global momentum gathering for global health, with special emphasis on gender, and align and integrate with efforts to achieve the Millennium Development Goals.
- Critical sources of leadership and accountability remain untapped. Emerging political powers, affected countries and people living with and vulnerable to HIV — including men who have sex with men, people who buy and sell sex and people who use drugs — must exercise greater leadership in the governance of HIV responses.

Mobilizing for impact: five recommendations

The present report contains the following five recommendations for all stakeholders:

- (a) Champion a prevention revolution that harnesses the energy of young people and the potential of new modes of communication that are transforming the world, rescinds punitive laws that block effective responses and ensures that people are empowered to protect themselves, their partners and their families from HIV;
- (b) Forge a revitalized framework for global solidarity to achieve universal access to HIV prevention, treatment, care and support by 2015;
- (c) Break the upward trajectory of costs and deliver more effective, efficient and sustainable programmes;
- (d) Ensure that our responses to HIV promote the health, human rights, security and dignity of women and girls;
- (e) Commit to forging robust mutual accountability mechanisms.

I. Introduction

1. When Member States convened at the United Nations in 2001 for the twenty-sixth special session of the General Assembly on HIV/AIDS, the world was losing the struggle against HIV. In 2001, the number of people living with HIV was increasing, therapies revolutionizing the HIV response in high-income countries were virtually unavailable in the most severely affected countries and total resources spent on HIV activities in low- and middle-income countries amounted to only about 10 per cent of spending in 2009. The epidemic was reversing decades of development progress in sub-Saharan Africa, threatening stability and security, and exacerbating global inequity in health.

2. The 2001 special session resulted in a visionary Declaration that included time-bound targets in the response. The special session gave rise to a major global health financing institution, namely the Global Fund to Fight AIDS, Tuberculosis and Malaria. Pledging additional steps to strengthen the response, Member States embraced a complementary set of commitments in the 2006 Political Declaration on HIV/AIDS, including the pledge to achieve universal access to HIV prevention, treatment, care and support.

3. Ten years after the landmark 2001 special session, the response to HIV has become perhaps the most compelling example of the power of international solidarity, evidence-informed action and political commitment. These achievements, although heartening, are exceedingly fragile.

4. The HIV response faces a moment of truth. HIV programmes are now bearing fruit, with the global HIV incidence declining, access to treatment expanding and a global movement mobilized to demand dignity and human rights for everyone affected by HIV. The HIV response has changed our world, elevating global inequity in health onto the political agenda, contributing to progress across the broad array of Millennium Development Goals and placing people at the centre of health and development efforts. These accomplishments, however, are in jeopardy. Aid fatigue and an enduring global economic downturn combine to threaten future support for essential initiatives.

5. The year 2011 is a historic marker in the global response; it allows the international community to review the progress of the last decade and marks 30 years into the epidemic. The international community must take this opportunity to reflect on lessons learned, reinvigorate and retool the response for the long term and maximize benefits for people most affected.

6. This report assesses progress and gaps in the response, based on data submitted by 182 countries and on national and regional reviews on universal access to HIV prevention, treatment, care and support.¹ Key findings include the following:

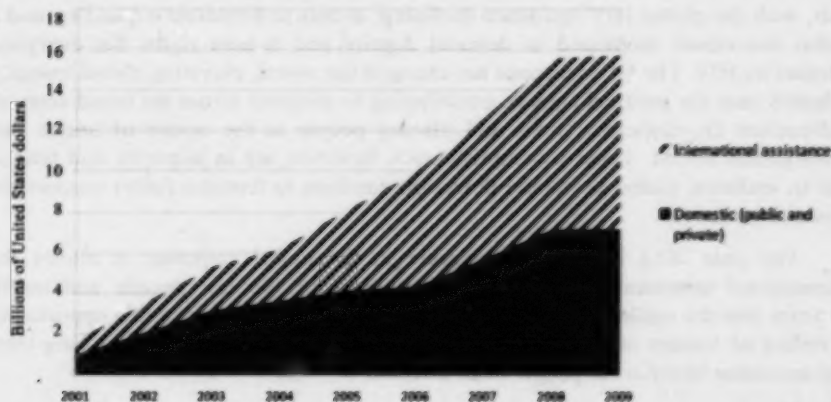
- **HIV prevention.** The number of people newly infected with HIV declined by 19 per cent in the decade before December 2009, with at least 33 countries experiencing a decline in HIV incidence of at least 25 per cent and 10 high-prevalence countries achieving the global goal of reducing HIV prevalence among young people by at least 25 per cent. Nevertheless, the epidemic

¹ Due to an inevitable lag in reporting from countries, this report relies mainly on data received as at December 2009.

continues to outpace the response, underscoring the need to revolutionize efforts to prevent new infections.

- **Antiretroviral therapy.** As at December 2010, more than six million people were estimated to be receiving antiretroviral therapy in low- and middle-income countries. Yet the majority of people in need still lack access.
- **Towards an HIV-free generation.** Global coverage for antiretroviral prophylaxis to prevent the vertical transmission of HIV has exceeded 50 per cent. However, more than 10 years after interventions were validated to prevent vertical transmission in resource-limited settings, the world remains far from achieving the goal of protecting newborns from becoming infected.
- **Human rights.** About three in 10 countries worldwide still lack laws prohibiting HIV-related discrimination. More than half of countries reported having laws or policies that indirectly or inadvertently reduce service access for vulnerable populations. Many of the countries with anti-discrimination laws do not rigorously enforce them.
- **Financing the response.** Funding for HIV programmes has dramatically increased, helping drive an overall surge in global health financing (see figure I). Nonetheless, in 2009, international HIV assistance declined for the first time, mirroring reductions in other forms of development aid.

Figure I
Total annual resources available for AIDS, 2001-2009



Source: Joint United Nations Programme on HIV/AIDS, 2011.

II. Thirty years of AIDS: reviewing the past, looking towards the future

7. In 2009, an estimated 33.3 million people were living with HIV, a 27 per cent increase from 1999 (see figure II). Globally, nearly 23 per cent of all people living with HIV are younger than age 24, and people age 15-24 account for 35 per cent of all people becoming newly infected. Sub-Saharan Africa remains the most severely affected region, accounting for 68 per cent of all people living with HIV, 69 per cent

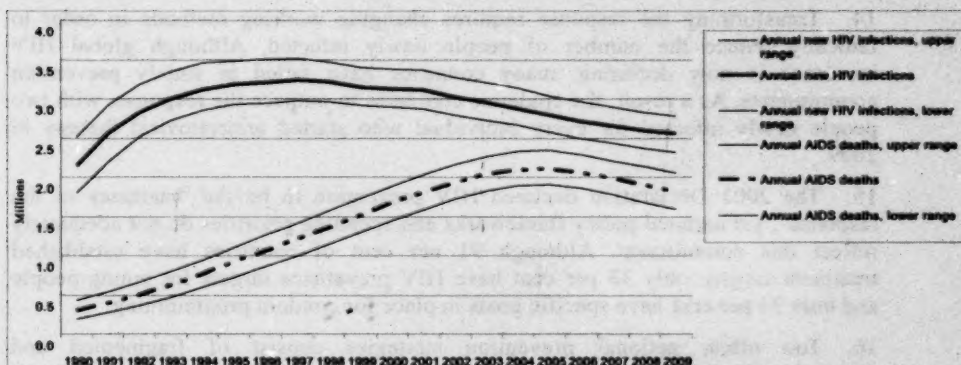
of new infections and 72 per cent of AIDS deaths. The epidemic, however, has not spared other regions; more than 10.8 million people are living with HIV outside sub-Saharan Africa. It continues to deepen poverty, increase hunger, slow progress on maternal and child health and exacerbate other infectious diseases.

8. The epidemic particularly affects women and girls. In 2009, women represented a slight majority (about 51 per cent of all people living with HIV and about 60 per cent of all people living with HIV in sub-Saharan Africa). Adolescent girls and young women in sub-Saharan Africa are several times more likely to be living with HIV than males of the same age.

9. Although global HIV incidence has declined, the number of people acquiring infection remains on the rise in Eastern Europe and Central Asia, North Africa and the Middle East and parts of Asia. The often-cyclical nature of sexually transmitted epidemics underscores the need for continued vigilance, as prevention strategies must be reinforced and adapted as young people become sexually active.

Figure II

Estimated number of new HIV infections and deaths due to AIDS, 1990-2009



Source: UNAIDS Report on the Global AIDS Epidemic 2010.

10. With the number of people receiving antiretroviral therapy increasing 13-fold from 2004 to 2009, the number of AIDS-related deaths declined by 19 per cent during the same period. Still, the epidemic continues to exact severe consequences. From 2005 to 2009, the number of children orphaned by AIDS increased from 14.6 million to 16.6 million.

The 2001 and 2006 Declarations: a framework for unprecedented progress

11. The 2001 Declaration of Commitment on HIV/AIDS helped to galvanize global resolve to reverse the epidemic. Outcome indicators were established to monitor implementation of the targets adopted in 2001, with countries submitting biennial progress reports to the Joint United Nations Programme on HIV/AIDS (UNAIDS). Civil society and people living with HIV have played an especially critical role in tracking progress in implementing the 2001 and 2006 Declarations, evaluating national policy responses and contributing to country-specific reviews.

12. The endorsement of the goal of universal access in 2006 substantially accelerated global momentum. More than 110 countries established clear,

time-bound national targets for service coverage. Although most countries are unlikely to have met their targets for 2010, advances over the last decade definitively demonstrate that universal access is both feasible and essential for long-term success.

III. Towards a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths

13. Accomplishments to date have been genuine and often historic, but the pace and reach of scaling up remains inadequate. The response needs to be transformed. In 2010, UNAIDS articulated a new vision for the response, that of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths. This new vision is intentionally ambitious, reflecting the high aspirations of a people-centred global movement.

A. Zero new infections

14. Transforming the response requires changing working methods in order to radically reduce the number of people newly infected. Although global HIV incidence is now declining, many countries have failed to satisfy prevention commitments. As a result, the epidemic continues to outpace the response, with two people newly infected for every individual who started antiretroviral therapy in 2009.

15. The 2001 Declaration declared HIV prevention to be the “mainstay of the response”, yet national policy frameworks and spending priorities do not adequately reflect this commitment. Although 91 per cent of countries have established treatment targets, only 33 per cent have HIV prevalence targets for young people and only 34 per cent have specific goals in place for condom programming.

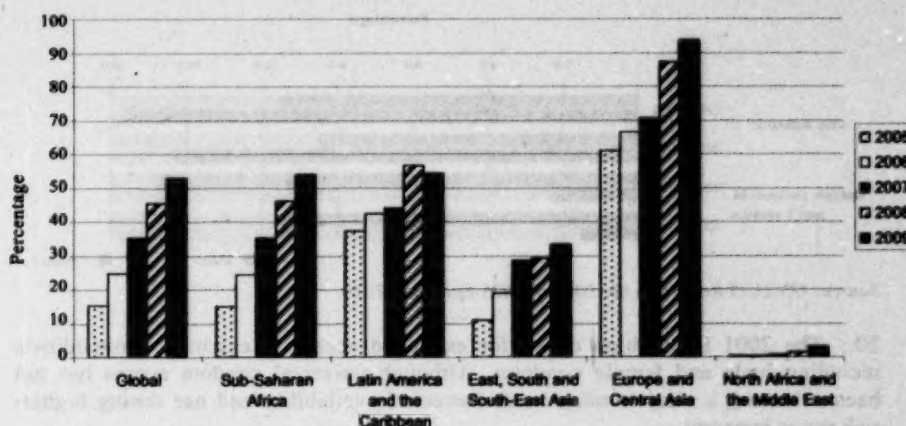
16. Too often, national prevention strategies consist of fragmented and disconnected programmes without clearly defined causal pathways, articulated synergies or target outcomes. In Asia, 90 per cent of prevention resources for young people support programmes focused on low-risk youth, who account for only 5 per cent of the people acquiring HIV infection. Similarly, in Eastern Europe and Central Asia, where epidemics are primarily concentrated among people who use drugs, 89 per cent of prevention investment fails to focus on the people at highest risk.

Progress in preventing vertical transmission

17. In recent years, a growing number of countries have laid the foundation for eliminating vertical transmission (see figure III). As at December 2009, 15 countries had achieved the target set in the 2001 Declaration of at least 80 per cent coverage of antiretroviral prophylaxis among pregnant women living with HIV, and an additional seven countries in sub-Saharan Africa reported coverage between 50 per cent and 80 per cent. Countries in Eastern Europe and Central Africa have achieved especially high coverage. As a result of scaled-up prevention services, the number of children newly infected declined by 24 per cent globally from 2004 to 2009.

Figure III

Coverage of antiretroviral drugs for preventing vertical transmission of HIV in low- and middle-income countries, globally and by geographical region, 2005-2009



Source: WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector — Progress Report 2010*.

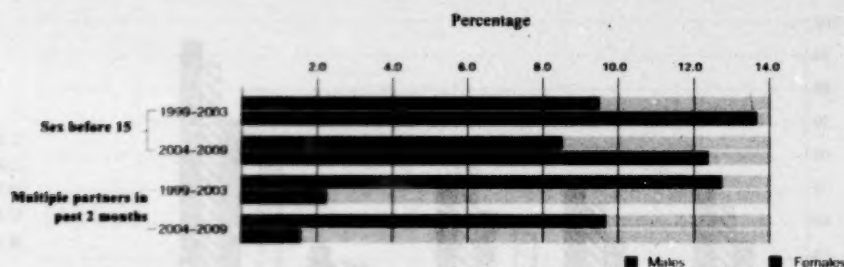
18. Eliminating vertical transmission requires far greater, and more rapid, advances to increase coverage and administer more effective regimens. Enhanced efforts are required to integrate HIV testing into antenatal services, since only 26 per cent of pregnant women in low- and middle-income countries were tested in 2009. Services to prevent mother-to-child transmission need to be more closely linked to sexual and reproductive health care. In 2009, 30 per cent of recipients of prevention services in antenatal settings received a suboptimal single-dose antiretroviral regimen, highlighting the importance of improving access to more efficacious combination regimens.

Encouraging trends among young people

19. Young people are leading the global prevention revolution. Among countries in which adult HIV prevalence exceeded 2 per cent, eight reported statistically significant declines in the percentage of girls who had sex before age 15, with seven countries reporting significant declines in early sexual debut among boys (see figure IV). Young people also show favourable trends in condom use (in 6 countries for young women and in 5 countries for young men) and number of sex partners (in 7 countries for young women and in 10 countries for young men). Although HIV-related knowledge among young people has increased, only 34 per cent of young people demonstrated accurate and comprehensive knowledge of HIV in 2009, well below the 95 per cent target identified in the 2001 Declaration of Commitment. Concerted action can address such knowledge deficits, as numerous countries — including Belarus, Chile and Eritrea — have demonstrated the feasibility of achieving rates of HIV-related knowledge exceeding 70 per cent among young people.

Figure IV

Young people and sexual risk: Proportion of people age 15-25 who had sex before age 15 and who had multiple partners in the past 12 months



Source: UNAIDS Report on the Global AIDS Epidemic 2010.

20. The 2001 Declaration called for expanded access to essential commodities, including male and female condoms. Although universal condom access has not been achieved, a clear trend towards increased availability and use during higher-risk sex is apparent.

Inadequate attention to the prevention needs of key populations at higher risk

21. The world will not be able to sharply lower the rate of HIV transmission without paying attention to the prevention needs of key populations at higher risk of exposure. However, as at 2009, only 26 per cent of countries had established prevention targets for sex workers, 30 per cent for people who used drugs and 18 per cent for men who had sex with men. Most countries do not report data on these key populations; many have little understanding of their size, age and geographical distribution. Resources allocated for prevention services for these groups are often minimal or non-existent. Other key populations that require heightened prevention support include prisoners, migrants, transgender people and people with disabilities.

22. According to data from 27 countries, only 32 per cent of people who injected drugs accessed HIV prevention services in 2009. In most countries surveyed in 2010, neither needle or syringe programmes nor long-acting opioid agonist therapy was available to reduce HIV transmission associated with drug use.

Making combination prevention a reality

23. To revolutionize HIV prevention, countries need to ground their national programmes in a thorough understanding of their epidemic and their response. Increasingly, countries are basing prevention strategies not on an understanding of the total number of people living with HIV (HIV prevalence), but rather on an improved understanding of the people newly infected with HIV (HIV incidence). As a result, a number of countries have taken steps to revise their prevention approaches to address emerging challenges and focus limited resources where they will have the greatest impact.

24. Combination prevention has been bolstered by the emergence of important new prevention tools, such as adult male circumcision, which reduces the risk of female-to-male sexual transmission by about 60 per cent. In 13 countries with high HIV prevalence and low prevalence of male circumcision, national situation

assessments have been conducted and strategic plans for scaling up circumcision developed. During the past two years, more than 200,000 men were circumcised in these 13 priority countries, including more than 90,000 in the Nyanza Province of Kenya alone.

25. Behavioural and biomedical approaches need to be supplemented with efforts that address the underlying social determinants of risk and vulnerability. In 2010, two studies in sub-Saharan Africa supported by the World Bank found that cash payments, contingent on adherence to recommended behaviour (such as staying in school or avoiding unprotected sex), reduced young people's risk of becoming infected with HIV or another sexually transmitted infection.

Emergence of critical new biomedical strategies for HIV prevention

26. During the past year, additional biomedical strategies have emerged to reduce the likelihood that any single sexual act will result in HIV transmission. In 2010, clinical trial results demonstrated that a vaginal microbicide could reduce a woman's risk of becoming infected during sexual intercourse. Additional trials are under way to confirm these results and to evaluate other microbicide candidates. If confirmed, these findings will help close a critical gap in the prevention toolkit: an effective prevention method that women may initiate on their own.

27. Also in 2010, a multi-country study found that a daily tablet containing the antiretroviral drugs tenofovir and emtricitabine reduced the risk of infection among men who had sex with men by 44 per cent. As in the case of microbicides, other trials are being conducted to confirm these results, including trials involving heterosexual cohort studies.

28. Each of these biomedical prevention advances involves unique and complex challenges. Additional studies are required to optimize acceptability, enhance adherence to prescribed protocols, monitor the risk of viral resistance in case of seroconversion and determine optimal service delivery models. National decision makers should expedite the integration of validated new tools into prevention programmes, where indicated, to increase the viability and sustainability of combination prevention efforts.

29. The search also continues for a preventive vaccine. Researchers have identified multiple antibodies that appear to neutralize HIV, providing important new avenues for vaccine development.

Integrating prevention and treatment

30. As the 2006 Political Declaration on HIV/AIDS emphasized, prevention, treatment, care and support are mutually reinforcing and must be closely linked. Emerging evidence of the important prevention benefits of antiretroviral therapy, which lowers viral load and thereby reduces the infectiousness of people living with HIV, merely underscores the need to link prevention and treatment efforts.

31. Separate planning approaches, however, are often undertaken for prevention and treatment. Little integration occurs at the level of service delivery. Referral systems for people who test HIV-positive are frequently fragmented and unmonitored. Prevention interventions have not been fully integrated in many clinical sites and about half of pregnant women testing HIV-positive in 2009 were not assessed for their eligibility to receive antiretroviral therapy. To strengthen links between prevention and treatment and to empower people living with HIV in prevention efforts, civil society partners joined with UNAIDS to call for

implementation of a strategy known as “positive health, dignity and prevention”. This strategy integrates prevention efforts into a holistic approach that takes account of the treatment needs and human rights of people living with HIV.

B. Zero discrimination

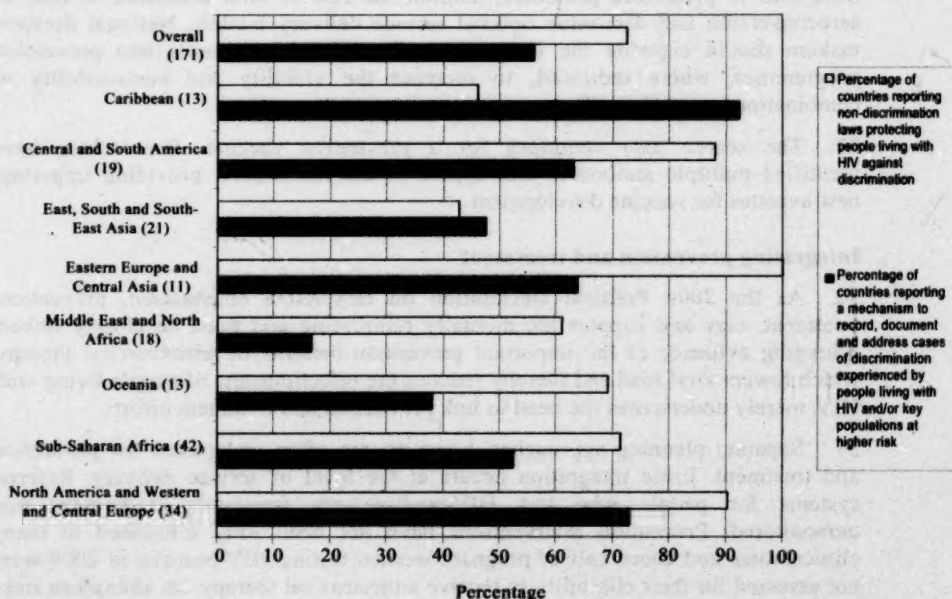
32. Thirty years after the epidemic was initially recognized, human rights violations continue to prevent open and compassionate discussion of the HIV challenge, deter individuals from seeking needed services, and increase individual vulnerability. An international survey of people living with HIV in 2010 found that more than one third had experienced loss of employment, denial of health care, social or vocational exclusion and/or involuntary disclosure. Globally, Governments cite stigma as the single greatest impediment to accelerated progress in the response. Social attitudes need to be transformed, and resources must be allocated to anti-stigma strategies and other initiatives to promote and protect human rights.

Inadequate protection against discrimination

33. The 2001 Declaration called on all Member States to have in place strong, enforceable measures to eliminate discrimination against people living with HIV or vulnerable groups. Although the number of countries reporting anti-discrimination laws in place increased from 56 per cent in 2006 to 71 per cent in 2010 (see figure V), it is disturbing that nearly 3 in 10 countries still lack such laws or regulations.

Figure V

Percentage of countries with legal protections against discrimination for people living with HIV and mechanisms for redress, as reported by non-governmental sources



Source: UNAIDS Report on the Global AIDS Epidemic 2010.

34. When anti-discrimination provisions are in place, they are often not effectively enforced. Globally, fewer than 60 per cent of countries report having a mechanism to record, document and address cases of HIV-related discrimination. In many countries, people living with HIV are at high risk of losing their homes, employment, property and inheritance due to inadequate protection.

35. In 2010, the vast majority of countries (91 per cent) addressed stigma and discrimination in their national HIV strategies, and 90 per cent of countries reported anti-stigma activities. However, most countries have no budget for anti-stigma activities.

36. Forty-nine countries, territories and entities impose some form of restriction on the entry, stay and residence of people living with HIV. Recent progress in this area is encouraging, as China, Namibia, Ukraine and the United States of America have repealed their respective HIV-based travel restrictions.

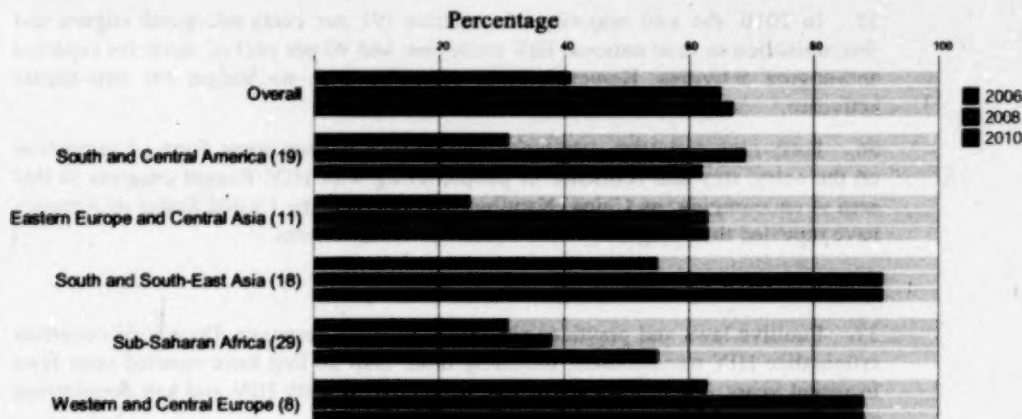
Discrimination against key populations at higher risk

37. Punitive laws and practices also undermine the response. Dozens of countries criminalize HIV transmission, including more than 20 that have enacted such laws in recent years. These laws stigmatize people living with HIV and key populations at higher risk without promoting public health goals.

38. Seventy-nine countries and territories criminalize same-sex sexual relations between consenting adults, and more than 100 countries criminalize aspects of sex work. In settings throughout the world, fear and social disapproval increase the vulnerability of mobile populations, prisoners, adolescents who practice high-risk behaviour and people in humanitarian settings. Such discrimination deepens social marginalization, increases the risk of harassment or violence and inhibits communities from mobilizing to address the epidemic.

39. Discriminatory policies also reduce access to essential prevention and treatment services. Among 106 countries, non-governmental sources in 62 per cent of countries reported that laws, regulations or policies were in place diminishing access to services for key populations at higher risk (see figure VI).

Figure VI
Percentage of countries in which non-governmental sources report laws or regulations that create obstacles to effective HIV prevention, treatment, care and support for population groups at higher risk and other vulnerable populations, 2006-2010



Source: UNAIDS Report on the Global AIDS Epidemic 2010.

Note: The following regions are not displayed owing to insufficient countries: Caribbean, Middle East and North Africa, East Asia, Oceania and North America.

40. Strong leadership helps overcome the legacy of discrimination. Recent years have witnessed the expansion of prevention programmes for men who have sex with men in China, the scaling up of community-centred services targeted for sex workers in India and the decision by a growing number of countries to remove restrictions on harm reduction programmes for people who use drugs.

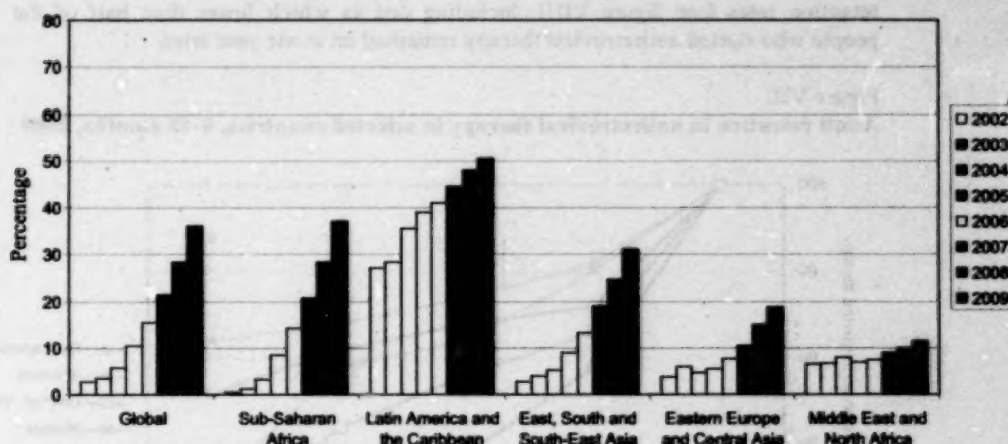
C. Zero AIDS-related deaths

41. Despite recent progress, nearly two in three people who are eligible for therapy still lack access. Transforming the response requires delivering life-preserving therapies to the people who need them, as well as new treatment, care and support approaches that are more sustainable.

Coverage is increasing but still inadequate

42. Recent gains in access to treatment are unprecedented (see figure VII). By the end of 2009, eight low- or middle-income countries were providing antiretroviral therapy to at least 80 per cent of the people eligible for treatment. Striking gains have been made in Eastern and Southern Africa.

Figure VII
Antiretroviral therapy coverage in low- and middle-income countries, globally and by region, 2002-2009



Source: WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector — Progress Report 2010*.

43. Yet these advances have failed to keep pace with the global need for treatment. About 10 million people who could benefit from treatment were not receiving it in 2009.

The quest for equitable access to treatment

44. Globally, treatment coverage is notably lower for children (28 per cent) than for adults (37 per cent). Historically, children's poorer access to treatment stemmed from the shortage of antiretroviral formulations for children, difficulties in diagnosing HIV among infants and the higher cost of drugs for children. An array of cost-effective antiretroviral formulations for children are now available, and improved technology permits rapid HIV diagnosis.

45. Marginalized populations also struggle to obtain equitable access to treatment, in part as a result of the hostility of many health-care workers. Among 21 countries reporting data on antiretroviral treatment utilization among people who injected drugs, 14 countries reached fewer than 5 per cent of such individuals.

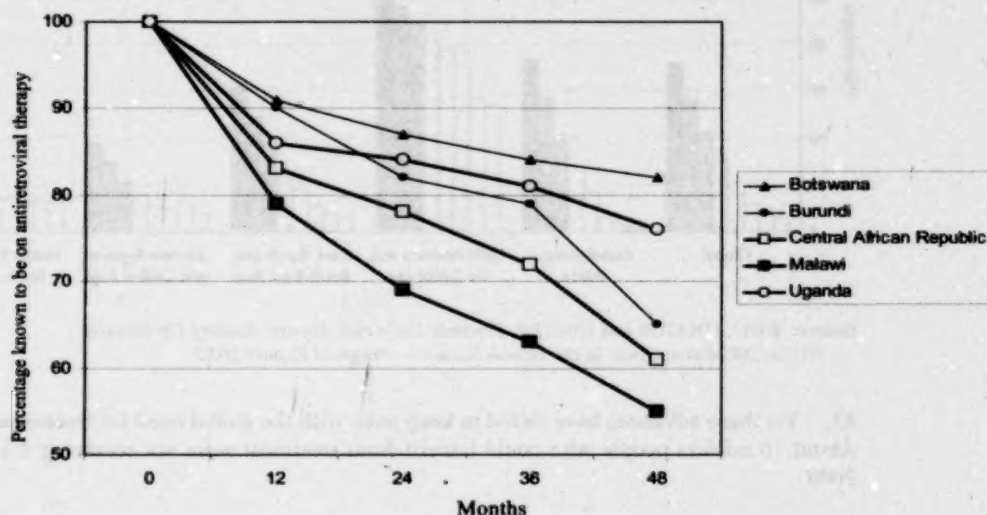
Timely diagnosis and continuity of care

46. Although HIV testing has increased in recent years, fewer than 40 per cent of people living with HIV were aware that they were infected in 2009. Adolescents have special difficulty in accessing testing services, and globally, only 6 per cent of babies born to women living with HIV are tested. In numerous countries, testing rates have sharply risen following implementation of provider-initiated testing and counselling, intensive national campaigns and mobile testing initiatives.

47. Maintaining health-care continuity is essential to favourable medical outcomes for people living with HIV. In 26 low- and middle-income countries, at least 95 per cent of all individuals who initiate antiretroviral therapy continue receiving treatment after one year. However, many countries report significantly lower retention rates (see figure VIII), including one in which fewer than half of the people who started antiretroviral therapy remained on it one year later.

Figure VIII

Adult retention in antiretroviral therapy in selected countries, 0–48 months, 2009



Source: WHO, UNAIDS and UNICEF, *Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector — Progress Report 2010*.

48. Several factors impede treatment uptake and contribute to dropout. These include inadequate or non-existent transport to distant clinical sites, insufficient support services, side effects associated with suboptimal treatment regimens, out-of-pocket expenses for non-drug components of treatment services, opportunity costs (such as lost income) associated with clinic attendance and inadequate human resources for health.

Management of tuberculosis and other co-occurring conditions

49. Tuberculosis remains a leading cause of death among people living with HIV. A more integrated approach to the delivery of HIV and tuberculosis services improves health outcomes and reduces service costs. The UNAIDS strategy for 2011–2015 and the Global Plan to Stop TB aim to reduce by 50 per cent the number of tuberculosis deaths among people living with HIV compared with 2004 through enhanced service collaboration.

50. Significant advances have been made in managing HIV and tuberculosis coinfection, but enormous gaps remain. In 2009, 26 per cent of people with tuberculosis were tested for HIV — up from 4 per cent in 2003, but far from

adequate. Fifty-five countries reported testing at least 75 per cent of all people with tuberculosis for HIV in 2009, many of them in African countries with a heavy HIV burden. Among the 450,000 people with tuberculosis who tested HIV-positive in 2009, only 37 per cent received antiretroviral therapy. An even greater access gap was reported for tuberculosis screening, with only 5 per cent of people living with HIV screened for tuberculosis. Only 0.2 per cent of people living with HIV received isoniazid preventive therapy.

51. The 2001 Declaration called for implementation of strategies to deliver comprehensive care to people living with HIV. Since people with HIV live longer as a result of treatment advances, cancers and other disorders associated with ageing are likely to become more prominent in HIV clinical settings, underscoring the need for preparedness to provide holistic care and support.

Care and support for children orphaned or made vulnerable by HIV

52. The 2001 Declaration committed Member States to implement policies to provide a supportive environment to orphans and vulnerable children, including access to schooling, shelter, proper nutrition and health and social services. In hyperendemic countries, HIV is responsible for more than one in three orphans. Although social protection initiatives improve HIV outcomes for children, too few children receive any form of external support free of charge. In a number of countries, the proportion of households with children orphaned or made vulnerable by AIDS receiving basic support actually declined from 2005 to 2010. Many efforts to address children's needs remain small-scale, even though more than 16 million children worldwide have been orphaned due to AIDS and millions more experience daily vulnerability as a result of the epidemic.

53. To strengthen the safety net for children affected by the epidemic, several countries have taken steps to implement social cash transfer programmes for vulnerable households. Countries that have expanded access to cash assistance for households with vulnerable children include Gabon, Malawi, Namibia and Zambia.

IV. Cross-cutting issues

54. Achieving the vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths requires substantially greater progress across a range of cross-cutting issues.

Gender equality and the empowerment of women and girls

55. Revolutionizing HIV prevention requires concrete progress towards gender equality. This priority is especially imperative in sub-Saharan Africa, where 76 per cent of all women living with HIV reside and where 13 women become infected for every 10 men.

56. This imbalance reflects not only the heightened physiological vulnerability of girls and young women, but also a high prevalence of intergenerational partnerships, lack of woman-initiated prevention methods and broader social and legal inequality that impedes the ability of young women to reduce their sexual risk. Women's odds of living with HIV are inversely correlated with educational attainment, a fact that highlights the role of universal education initiatives in reducing HIV-related

vulnerability. Women also bear a disproportionate share of the HIV-related caregiving burden and are often more likely to be the victims of discrimination.

57. Despite the epidemic's enormous toll on women and girls, fewer than half of countries provide a specific budget for HIV-related programmes for women and girls. The prevalence of gender-based violence is as high as 50 per cent in some countries, with one of four women in sub-Saharan Africa reporting that their first sexual experience was coerced. Few programmes are in place to engage men and boys in efforts to eliminate gender-based violence and inculcate healthier gender norms. Zero tolerance of gender-based violence must be a shared goal.

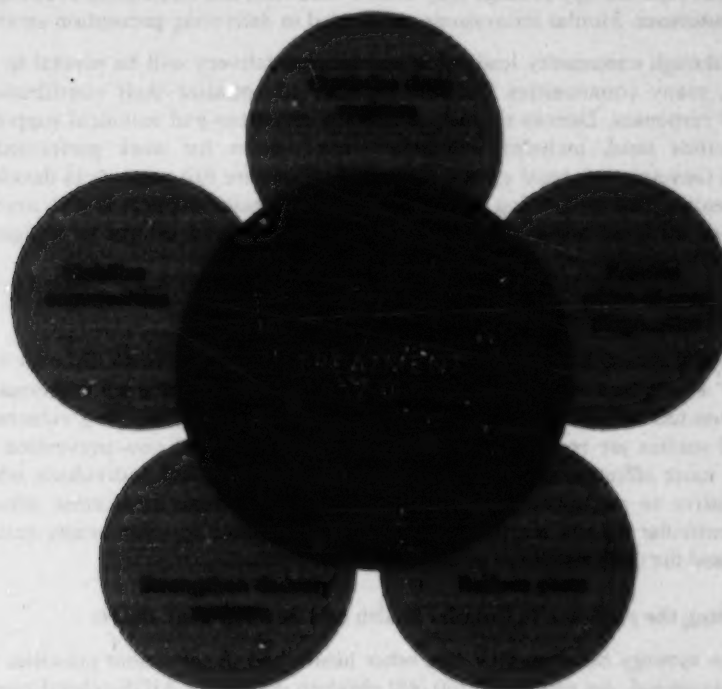
Robust and sustained financing for the response

58. Only a collective sense of shared responsibility and accountability will ensure that the response has sufficient resources in future years. In 2009, low- and middle-income countries accounted for 52 per cent of HIV expenditure. However, many low-income countries remain almost wholly dependent on external support.

59. Many countries, including some with severe and growing epidemics, have not given the response the priority it deserves. Middle-income countries, in particular, should cover their own HIV-related costs, with the possible exception of a few hyperendemic countries that will need continued assistance. Low-income countries will remain largely dependent on international AIDS assistance in future years, highlighting the need for more effective use of resources, streamlined donor reporting requirements, alignment with national strategies and institutions and more predictable funding. However, even low-income countries have an important role to play in funding and taking ownership of their response. Long-term financing for the response highlights the urgent need for sustained support to the Global Fund.

60. As efforts are made to mobilize new resources for the response, intensified attention must focus on maximizing the efficient use of available resources. The Treatment 2.0 approach, a new treatment platform launched by UNAIDS in 2010 (see figure IX), aims to optimize the long-term benefits of HIV treatment while implementing measures to increase efficiency.

Figure IX
Five pillars of Treatment 2.0



61. Lowering the costs of HIV commodities is critical. The number of countries that allow for flexibilities in intellectual property rules has declined in recent years, and a growing array of bilateral and regional trade agreements are undermining the ability of countries to maximize these flexibilities to promote access to essential medicines.

Building sustainable capacity

62. Both the 2001 and 2006 Declarations recognize the importance of strengthening systems. The challenges the epidemic poses to fragile health systems are especially evident in sub-Saharan Africa, home to more than two of three people living with HIV, but to only 3 per cent of the world's health-care providers. There are encouraging signs of resilience as health systems struggle to cope with the epidemic's demands. The number of health facilities administering antiretroviral therapy rose by 36 per cent from 2008 to 2009. Studies indicate that HIV programmes are conferring broad benefits on health systems, refurbishing clinics, strengthening commodity procurement and supply management and building national capacity for monitoring and evaluation.

63. Underlying weaknesses in health systems continue to undermine efforts to expand service access. Of 94 countries reporting, 38 per cent had at least one drug stock out in 2009. Current models for expanding treatment, which are heavily hospital- and physician-intensive, strengthen the effects of health worker shortages

and underscore the need for greater task-shifting of clinical duties to lower-level staff. Studies confirm that the greater use of nurses, mid-level staff and lay workers in antiretroviral therapy settings may enable excellent, and sometimes even superior, health outcomes. Similar innovations are needed in delivering prevention services.

64. Although community leadership and service delivery will be pivotal to future success, many communities lack the capacity to optimize their contributions to national responses. Donors should provide the resources and technical support that communities need, including adequate compensation for work performed, and national Governments must ensure that communities are full partners in developing, implementing and monitoring AIDS strategies. Increased support is also needed to strengthen national social protection systems to improve efforts to mitigate the impact of the epidemic.

Expanding the evidence base for action

65. Robust research efforts are needed to accelerate the drive to discover a cure, develop a safe and effective vaccine, expedite the emergence of additional new prevention technologies and better understand and address underlying vulnerability. Focused studies are required to expedite the introduction of new prevention tools, identify more effective strategies to increase HIV testing, link individuals who test HIV-positive to continuous, high-quality care and increase medication adherence rates. Particular efforts are required to increase support for community-generated studies and the documentation of best practices.

Integrating the response in broader health and development efforts

66. The synergy between HIV and other health and development priorities needs to be maximized. An estimated 260,000 children died from AIDS-related causes in 2009, and HIV is a key factor in an estimated 20 per cent of all maternal deaths. HIV deepens poverty, exacerbates hunger and contributes to higher rates of tuberculosis and other infectious diseases. Conversely, progress on other development priorities, such as universal schooling, gender equality and health system strengthening, helps bolster HIV responses. Achieving this synergy requires integrating HIV within the broader development agendas at the levels of strategic planning, service delivery, advocacy and partnership cultivation.

HIV and security

67. Significant changes have occurred in the landscape of demographic crises and conflicts. Evolving challenges and new risks elevate the need for strengthened HIV responses in the context of efforts of the United Nations to prevent conflict, promote security, strengthen fragile States and build peace. A new course of action is needed that mobilizes the millions of members of uniformed services as important agents of change — especially in combating all types of violence against women — and aligns strategies for HIV prevention with conflict, post-conflict and peacebuilding operations.

V. A call to action: five recommendations

68. At this pivotal juncture, it is necessary to dramatically reshape the HIV response to reach zero new HIV infections, zero discrimination and zero AIDS-

related deaths. This requires rejuvenated political leadership for more focused, efficient and sustainable responses that are aligned with broader health, development and human rights agendas.

69. The Secretary-General calls on all leaders to take advantage of this turning point in the epidemic: an AIDS transition that sees fewer people newly infected than those who start receiving treatment is an attainable target. The international community must intensify its efforts if it is to achieve, by 2015, universal access to HIV prevention, treatment, care and support and other unmet targets of the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, and to implement the action agenda of the 2010 outcome document entitled "Keeping the promise: united to achieve the Millennium Development Goals" (see General Assembly resolution 65/1).

70. Every aspect of the response must reflect a shared commitment to transformative social change for health, development and human rights. It must incentivize leaders to take bold action to bring about such change. It must be ensured that the HIV response is sustained as a political priority, taken out of isolation and leveraged to reinforce the social fabric of our societies. It must strengthen the systems that deliver critical services to the most vulnerable and marginalized members of our communities.

A. End new HIV infections

71. Ending new infections will require responding to a fast-changing world, which is marked increasingly by urbanization, human mobility and insecurity. Thirty years into the epidemic, HIV prevention and treatment efforts are increasingly unified to more efficiently achieve the shared outcomes of fewer new infections and fewer people dying. Putting people living with HIV at the centre of the response is therefore critical. It must be recognized that inclusion, non-discrimination, pragmatism and compassion will yield benefits not only for the HIV response but also across health, development and human rights priorities.

72. The Secretary-General therefore calls on all Member States, civil society, the private sector and other actors to champion a prevention revolution that harnesses the energy of young people and the potential of new modes of connection and communication that are transforming the world, that rescinds punitive laws that block effective responses and ensures people are empowered to protect themselves, their partners and their families from HIV by undertaking the following actions:

(a) Commit to averting the maximum number of HIV infections for each dollar spent by focusing evidence-informed and rights-based efforts on the populations that account for the largest share of new infections and by saturating transmission hot spots with proven interventions such as female and male condom promotion, male circumcision, treatment as prevention, harm reduction for drug users and "Positive health, dignity and prevention" approaches that link the social and health needs of people living with HIV within a human rights framework;

(b) Ensure that legal, political and social environments enable effective HIV responses — including through protective laws, supportive law enforcement and access to justice — to eradicate HIV-related stigma and discrimination and to enable equitable access to HIV-related information and services, especially for people who

use drugs, men who have sex with men, people who buy and sell sex, young people and populations affected by humanitarian situations;

(c) Scale up research investments to accelerate the development of vaccines, female-controlled methods, microbicides and other prevention tools, and enhance collaboration among scientists, the private sector, Governments and communities to expedite the introduction of, and equitable access to, validated new tools as they emerge.

B. Share responsibility and build ownership for sustainable outcomes

73. While some \$16 billion was available for the global response in 2010, a significant gap remains between investment needs and available resources, and the gap is widening. It is imperative to ensure the sustainability of efforts, including protecting access for the more than 6 million people receiving treatment in low- and middle-income countries and ensuring access for the millions who are still in need. Countries must commit to global solidarity, built on the tenets of shared responsibility, true national ownership and mutual accountability. The global South must exercise greater leadership in the governance of AIDS responses at all levels. Let the AIDS response be a beacon of global solidarity for health as a human right and set the stage for a future United Nations framework convention on global health.

74. The Secretary-General therefore calls on Member States, and all actors in the response to HIV, to undertake the following actions in forging a revitalized framework for global solidarity to reach universal access to HIV prevention, treatment, care and support by 2015:

(a) Exercise inclusive and accountable leadership, and create space for national debate on priorities, strategic investments, social protection and legal measures to foster broad ownership and access to entitlements, ensuring that people living with and vulnerable to HIV — young and old — are able to act as partners in the governance, design, delivery and evaluation of the response;

(b) Meet fair-share commitments to reach investment needs, whereby international donors realize their long-term, predictable financing commitments and domestic investment in low- and middle-income countries is significantly scaled up, emerging political and economic powers assume their share in international and regional leadership for the AIDS response, and innovative financing mechanisms are expanded;

(c) Actively support and strengthen the capacity of national institutions, community systems and human resources for health to mount evidence-informed and rights-based responses, including by promoting South-South cooperation and using regionally sourced technical support.

C. Break the upward trajectory of costs

75. National responses must move from crisis management to change management. Success depends on focusing resources on actions that will generate results and efficiency while promoting country- and people-owned responses. Strengthening national and community institutions and democratizing problem-

solving will result in more locally appropriate, broadly owned responses and client-centered care at lower costs, and this will drive long-term sustainability.

76. The Secretary-General therefore urges Governments, civil society, the private sector and other actors to commit to the following actions to break the upward trajectory of costs and to deliver more efficient and sustainable programmes:

(a) Catalyse efficiency-generating innovation in treatment access, including through the Treatment 2.0 agenda, by fostering development, in cooperation with the pharmaceutical industry, of more affordable, more resilient, less toxic, longer-acting and easier-to-use drug regimens, by significantly scaling up access to point-of-care diagnostics and clinical monitoring tools, by supporting countries in taking full advantage of the flexibilities inherent in the Doha Declaration on the TRIPS Agreement and Public Health and ensuring that other trade agreements do not undermine these flexibilities, by expanding patent pools, and by enhancing access to all essential medicines at sustainable prices;

(b) Maximize efficiency in non-drug-related costs, including by decentralizing services, task-shifting and building the capacity of community health workers, and strengthening community systems and rights-based approaches in service delivery;

(c) Work with partners to ensure that synergies are exploited between the HIV response and efforts to achieve the Millennium Development Goals, including by scaling up efforts to coherently address HIV and tuberculosis coinfection, by leveraging the AIDS response to improve maternal, child and sexual and reproductive health outcomes, and by integrating HIV-related services with food and nutrition support and, where appropriate, services for chronic illnesses, including providing palliative care and addressing opportunistic infections, cardiovascular disease, diabetes and hepatitis C.

D. Foment a social revolution for women and girls

77. Gender inequality, harmful gender norms and violence compromise the ability of women and girls to protect themselves from HIV, and therefore fuel the epidemic. The establishment of UN-Women, as well as the UNiTE to End Violence against Women campaign, marks a new phase in the commitment of the United Nations and Member States to gender equality and empowering women. The HIV and women's movements must unite to empower women and girls, especially young women, to know and demand their rights, including protection from sexual coercion and violence and access to gender-sensitive and gender-transformative HIV-related programmes.

78. The Secretary-General therefore urges all stakeholders to ensure that the status of women and girls in our societies and our responses to HIV promote their health, human rights, security and dignity, including through the following actions:

(a) Take specific measures, from households to parliaments, to empower women and girls by reversing harmful gender norms, by ensuring that legal frameworks provide equal rights and equal access to justice and security for women and girls, by protecting the rights of women and girls living with HIV, including their sexual and reproductive health and human rights, by strengthening social protection, care and support programmes for children affected by AIDS, and by

scaling up programmes to eliminate gender-based violence as a cause and consequence of HIV that also engage men and boys;

(b) Ensure national responses meet the HIV-specific needs of women and girls across the span of their lives and actively confront and eradicate gender inequality-driven gaps in access to HIV-related information, services and commodities, including for women and girls affected by humanitarian situations;

(c) Support the Global Strategy for Women's and Children's Health and the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV in order to deliver a comprehensive, integrated HIV, tuberculosis and sexual and reproductive health package addressing the broader health needs of women and children, including orphans, leveraging services to prevent vertical HIV transmission as an entry point to deliver a range of services to women, children and families.

E. Ensure mutual accountability for universal access

79. Although sustained political commitment, human resources and financial support are essential for achieving universal access, they do not guarantee results. Robust systems of accountability are key to success. These must start with systems for data collection and analysis that result in policies and programmes tailored to populations; modes of transmission; geographical settings; and programmatic, legal and structural gaps in the response.

80. The Secretary-General therefore recommends that Member States, civil society and other stakeholders commit to forging robust mutual accountability mechanisms for the translation of commitments into action, through the following actions:

(a) Countries set ambitious national targets to fully achieve universal access based on "know your epidemic, know your response" methods; work with UNAIDS to develop a revised framework of core global indicators that respond to new global commitments and goals; mount periodic and inclusive evidence-informed and rights-based reviews of progress towards national targets; and, with the support of UNAIDS, submit a progress report to the Secretary-General in accordance with global reporting on the Millennium Development Goals at the special event of the General Assembly on the Millennium Development Goals in 2013 and subsequent Millennium Development Goal reviews;

(b) Establish annual peer-based regional reviews, organized by competent regional political bodies and with the support of the relevant United Nations regional commissions and UNAIDS, that facilitate the engagement of health and non-traditional yet key ministries such as justice, finance, public security and law enforcement;

(c) Identify substantive roles (such as co-chairing), as well as financial support for participation, in national and regional reviews for delegations of civil society and affected communities, including people living with HIV, people who use drugs, men who have sex with men, people who buy and sell sex and young people.

Global goals for 2015

In committing to the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths, the international community must hold itself accountable for reaching shared goals that will rewrite the future for generations. The UNAIDS strategy for 2011-2015 presents a number of ambitious goals to lead and galvanize the United Nations system, and the entire global response, to deliver transformative results.

In order to accelerate progress in all the goals set out in the UNAIDS strategy, commit to bringing about measurable impact on the lives of the people most affected and focus efforts on the most critical pillars of the response, the Secretary-General urges that the global community adopt the following goals for 2015:

(a) The prevention imperative is upon us. The human, social, economic and hence political costs of insufficient action will be extremely high. The Secretary-General therefore urges Member States to commit to reducing by 50 per cent sexual transmission of HIV — including among key populations, such as young people and men who have sex with men and in the context of sex work — and to preventing all new HIV infections as a result of injecting drug use;

(b) Global solidarity has brought treatment to more than 6 million people living with HIV. Through innovation, in drugs, pricing and delivery systems, it is possible to bring down costs, prevent new infections and achieve universal access to treatment. The Secretary-General therefore calls on Member States to ensure that 13 million people are receiving HIV treatment by 2015;

(c) Tuberculosis remains the leading cause of death among people living with HIV, despite being preventable and curable. The Secretary-General therefore calls on Member States to commit to reducing by 50 per cent tuberculosis deaths among people living with HIV;

(d) It is a grave global injustice that 370,000 newborns contract HIV in low- and middle-income countries each year, while vertical transmission has been virtually eliminated in high-income countries. The Secretary-General therefore calls on Member States to come together to eliminate vertical transmission of HIV, and in so doing, keep mothers alive, prevent children from becoming orphans and improve the health of women, children and families;

(e) Children continue to be severely impacted by the epidemic, with great demands placed on caregivers. Children who have lost both parents have less access to education than non-orphans. The Secretary-General therefore urges Member States to commit to ensuring that the most vulnerable children affected by AIDS are supported to stay in school, including through the creation of safe and non-stigmatizing learning environments and the expansion of social protection and care and support programmes for the most vulnerable families, with a target of equal education access between orphans and non-orphans by 2015;

(f) Institutionalized discrimination targeted at people living with HIV continues to undermine every effort made in the AIDS response. The Secretary-General therefore urges Member States to commit to reducing by 50 per cent the number of countries with HIV-related restrictions on entry, stay and residence.

81. It is the firm conviction of the Secretary-General that these six goals can be achieved. This conviction is based on the history of the AIDS response: a history marked by human courage and led by people living with HIV, which has refashioned human aspirations, transformed institutions and delivered remarkable results against inimitable odds.

82. The United Nations has played an important part in this history. UNAIDS continues to be at the centre of these efforts. In the midst of a proliferation of development efforts, UNAIDS has modelled United Nations reform in action and has united the global community around a shared agenda, conveying the demands of the people and catalysing commitment and action at all levels.

83. By working together to execute these recommendations, the international community can achieve these goals by 2015, and take an extraordinary and unified step towards a world of "zero, zero, zero".